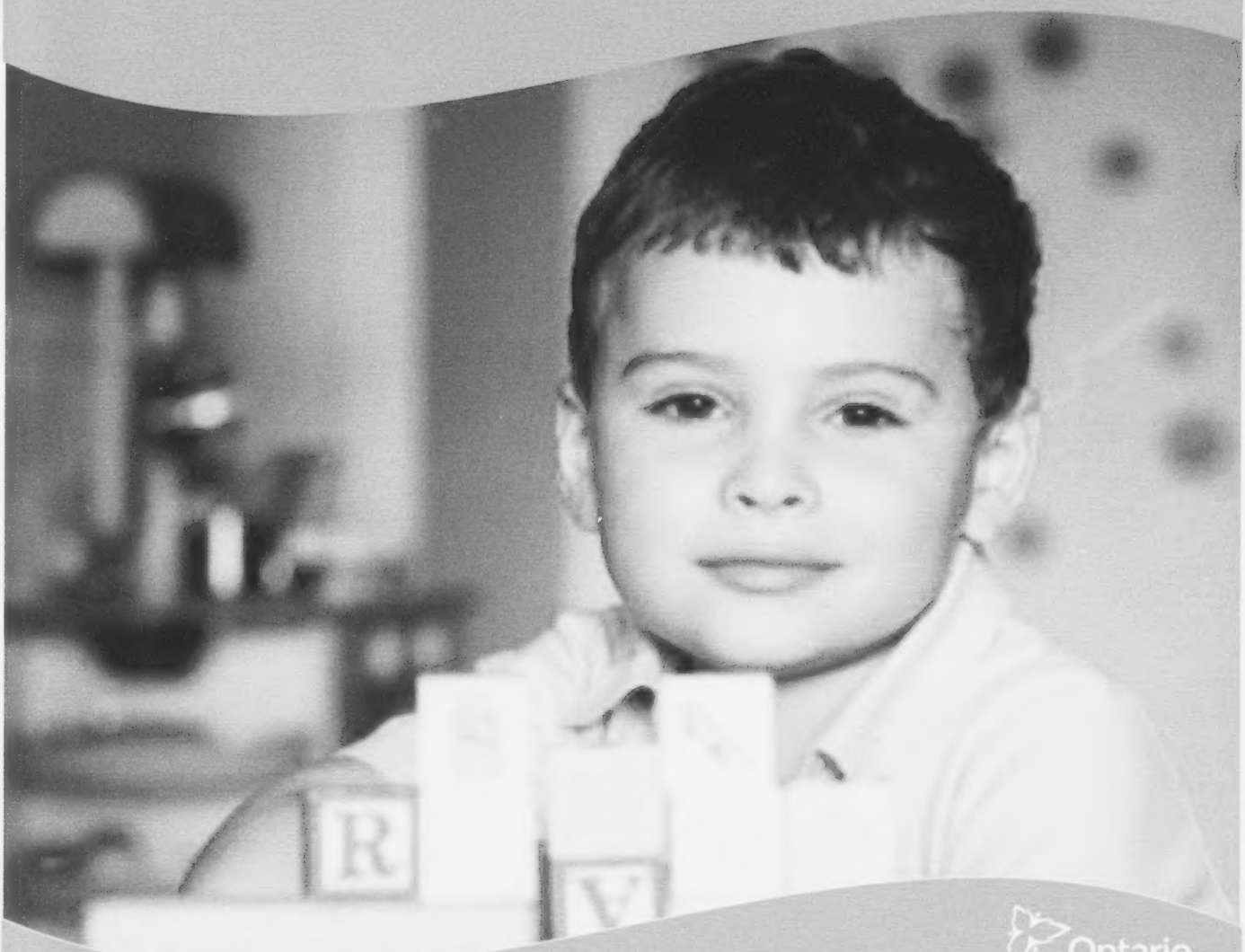
North West **LHIN**

Building Our Future

2011 – 2012 Annual Report



Ontario
Local Health Integration Network

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Message from the Chair and CEO

Joy Warkentin
Chair

Laura Kokocinski
CEO

We are very proud to deliver the 2011-2012 annual report for the North West Local Health Integration Network. This document highlights the activities and accomplishments achieved over the past year through collaboration and partnership with health service providers in our region. Together, we have focused on improving the health of the population, enhancing quality of care, improving access to care, and creating a sustainable health care system for future generations to come.

The last 12 months have been challenging, stimulating, rewarding and, in the life of a still fairly young organization, extremely significant. It was by no means an easy year in health care. Economist Don Drummond released a widely discussed report calling for deep cuts to health care, and the provincial government released its own Action Plan outlining ways in which the system has to be transformed.

Despite the challenging environment in Ontario, we pursued our course of action with a focus on patient-centered care in the Northwest. Health care is about patients and their families, and over the past year we have worked extremely hard to improve the health services on which people in our region depend. Many of the accomplishments listed below could not have been achieved without the support and hard work of the health service providers in our region. Together, we:

- Created our vision and model for an integrated health care system for the North West LHIN - a 10-year plan called the "Health Services Blueprint: Building Our Future".

- Expanded our community support services through the addition of: 12,775 placement days in supportive housing, 3,650 annual placement days of interim long-term care in Kenora, as well as 7,300 annual placement days in long-term care in Terrace Bay. These activities enable more seniors to live safely and with dignity at home in their communities.

- Achieved provincial targets for non-admitted emergency department wait times, with 93% of the individuals discharged to home within 8 hours or less.

- Decreased the number of Alternate Level of Care patients waiting in hospital for long-term care by 39%. This was accomplished by changing the focus to *Home First*.

- Lowered our wait times for cancer surgery by 18% and cataract surgery by 8%. We

exceeded provincial targets for both categories.

- Met, and exceeded, our target for the number of eHealth projects delivered, building greater connectivity between and among health care providers to enhance client care.

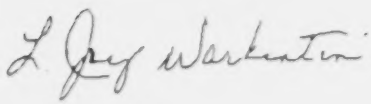
These are all significant accomplishments, but the most transformative event of the year was the release in March of the *North West LHIN Health Services Blueprint: Building Our Future*. The Health Services Blueprint lays the foundation for advancing the integration of health services in the Northwest, making services more accessible for patients as close to home as possible while creating a sustainable health care system for generations to come.

The Health Services Blueprint is, as the name suggests, a roadmap and model of an integrated health care delivery system that will serve the people of Northwestern Ontario. Throughout the course of the 10-year plan, we will work closely with health service providers and partners to provide integrated services at the local, district and regional levels.

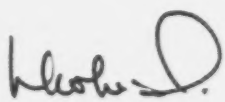
As a catalyst for change, the North West LHIN plans and manages the health care system with a view from the patient and system perspective. Our focus is to improve population health outcomes, care experience, and access to high quality care while ensuring there is value and return on the investments we have made. We are creating a smooth functioning, accessible, patient-friendly and efficient system.

We would like to acknowledge the role of our stakeholders in the creation of the Blueprint. We consulted widely, and the feedback received was extremely valuable. Going forward, we are counting on our partners in health care, particularly health service providers funded by the LHIN, to help lead the implementation of the recommendations of the Blueprint.

Over the past 12 months, health care in the Northwest took a bold step forward; one that will help us ensure that people of the Northwest remain at the heart of our health care system. We look forward to another exciting year ahead as we work together to improve the health system in Northwestern Ontario.



Joy Warkentin
Chair



Laura Kokocinski
CEO

Board of Directors

The North West LHIN is governed by a government-appointed, skills-based Board of Directors, accountable – through the Chair – to the Minister of Health and Long-Term Care for the LHIN's use of public funds, for achieving results through execution of its strategic directions and for the performance of the local health system.

The LHIN Board has adopted a policy governance model with a focus on:

- Addressing population health.
- Improving the patient experience.
- Ensuring good value for money.

Directors are appointed by Order-in-Council for a term of one to three years, subject to a six-year maximum.

2010-2013 Strategic Directions

The North West LHIN Board of Directors' Strategic Plan *2010-2013 Leading Health System Transformation in Our Communities* provides a common vision and common directions to the LHIN and health service providers for the health system until 2013.

Four strategic directions are outlined in the plan:

1. Improved health outcomes resulting in healthier people.
2. Access to health care that people need, as close to home as possible.
3. Continuous quality improvement.
4. Well-managed resources.

As the North West LHIN works together in partnership with its health service providers to achieve the goals in the strategic plan together, positive changes will take place to improve people's health and care experiences, and to better utilize and manage available resources.

Our Mission

Develop an innovative, sustainable and efficient health system in service to the health and wellness of the people of the North West LHIN.

Our Vision

Healthier people, a strong health system – our future.

Our Values

1. Person-Centered
2. Culturally Sensitive
3. Sustainable
4. Accountable
5. Collaborative
6. Innovative

Members of the Board

Joy Warkentin, Chair
Thunder Bay

Term: January 27, 2010
to January 26,2013
Appointed Chair
August 21, 2011

Anne Krassilowsky, Vice Chair, Dryden

Term: May 17, 2011
to May 16, 2014

Reg Jones, Secretary
Thunder Bay

Term: April 18, 2011
to April 17, 2014

Dennis Gushulak
Ear Falls

Term: July 28, 2010
to July 27, 2013

Dan Levesque
Geraldton

Term: April 18, 2011
to April 17, 2014

Dianne Loubier
Ignace

Term: August 21, 2011
to August 20, 2013

Dianne Miller
Thunder Bay

Term: November 18, 2009
to November 17, 2012

Gary Phillips
Thunder Bay

Term: November 18, 2009
to November 17, 2012

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Goyce Kakegamic
Thunder Bay

Appointed May 4, 2011
Resigned December 8, 2011

Introduction

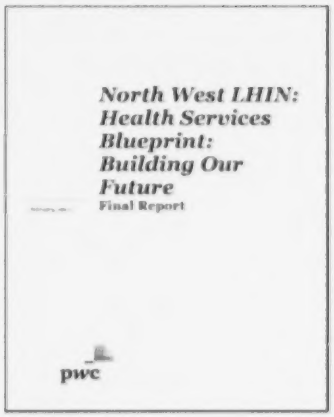
Local Health Integration Networks were created by the government of Ontario in 2006 to plan, fund and integrate health services. Their mandate was to do this through, as their name suggests, better integration of the respective health sectors and health care organizations.

Integration is widely understood to be a critical component of any effort to improve the quality, efficiency and sustainability of health care systems. By encouraging health providers to form stronger partnerships devoted to improving patient outcomes, health planners can eliminate the duplication and gaps in service that currently exist, improve coordination of services, achieve better health planning and, most important of all, ensure that the patient is always at the centre of the health care system.

Since 2006, the North West LHIN has been moving forward with an integration agenda for health care in Northwestern Ontario. Steady progress has been made through a series of programs and initiatives designed to improve health services and access to those services throughout the LHIN.

Even with this progress, health service providers were requesting greater understanding and advice related to integration. As a result, in 2011-2012 our LHIN took an enormous stride forward towards creating a better integrated health care system in Northwestern Ontario through the development of our 10-year plan - the *North West LHIN Health Services Blueprint: Building Our Future*.

Health Services Blueprint: Building Our Future



The Health Services Blueprint, released by the North West LHIN in March 2012, is a comprehensive 10-year plan designed to strengthen the health care system in Northwestern Ontario through an integrated patient-centred model of care. This transformational change will help reshape the health care system in our region to make it sustainable for the future.

Informing the Blueprint

The Blueprint was prepared for the LHIN by PricewaterhouseCoopers (PwC) and is the product of 18 months of research and consultation informed by people in the Northwest. To achieve this end, PwC and the North West LHIN:

- Studied five best practice models of integrated health service delivery systems in other northern, rural and remote jurisdictions both in Canada and internationally.
- Conducted an inventory of all the health services and health human resources available across the North West LHIN.
- Studied and mapped patient experiences with the health care system, to identify strengths and weaknesses, and create what the ideal patient journey should look like in the future.
- Engaged 188 health service providers and other stakeholders in 17 sessions in 12 communities across the region.
- Surveyed 410 health care providers.
- Collected and analyzed available health system data.

The Case for Change

Like most jurisdictions around the world, health care in Ontario faces a very serious fiscal challenge. Today, the province is spending 42 cents of every dollar on health care. This is expected to increase to 70 cents of every dollar within 12 years if nothing changes.[1]

The Ontario government released its Action Plan for Health Care in January 2012 aimed at strengthening and protecting the province's health care system in order to meet future demand. The Action Plan is focused on changes that will improve the patient care experience - all based on evidence. Our Health Services Blueprint is aligned with the provincial Action Plan. Key findings from the data provide evidence that:

1) The North West LHIN has a high rate of preventable disease compared to the provincial average. For example:
   a. More people smoke, drink heavily and are overweight compared with the provincial average, contributing to risk factors for certain chronic diseases.
   b. 25% of people over age 65 have diabetes compared to 20% provincially
   c. 58% of people over age 65 have high blood pressure compared to 51% provincially.
   d. 23% of people over age 14 have arthritis compared to17% provincially.

2) Transitions between care settings are not handled efficiently and effectively. This means that patients frequently wait too long in hospital until home care or long-term care is available, and all too often do not receive the post-discharge support that they need. As a result, readmission rates in the North West LHIN are very high. Reducing readmission rates by improving access to community-based care has significant benefits for patients, their families and the system as a whole.

3) The Northwest has the highest rate of acute care use in the province. This is because patients are visiting the hospital with health problems that could be treated in their communities at a lower cost and with better health outcomes. The number of repeat emergency department visits is 28% higher than the provincial average.

4) Patients with chronic diseases can be managed more effectively in the community. North West LHIN area residents have high rates of hospitalizations and emergency department visits for many chronic diseases, suggesting the need for more community-based services like primary care offered by family physicians, Nurse Practitioner-Led Clinics, walk-in clinics, or other community-based programs.

5) Health costs are higher in the North West LHIN. In 2009-10[2], health care spending in our region was 39% higher than the provincial average in almost every sector. This is in part because the LHIN has a large rural and remote population across a vast geography. These individuals face challenges accessing the same services that are available in larger centres. Helping them access care is expensive.

The Blueprint

The Health Services Blueprint contains 44 recommendations designed to improve the way the North West LHIN allocates health care resources over the next 10 years to ensure the best possible care experience and health outcomes. Once implemented, the recommendations will create an integrated health care delivery system where providers explore new partnerships in order to better deliver services to people across the Northwest.

The new health care service delivery model proposed in the Blueprint will see all LHIN-funded health service providers organize the delivery of care within three planning levels:

[1] Ontario's Action Plan for Health Care, 2012

[2] The most current information available

Local Health Hubs, Integrated District Networks, and Regional or LHIN-Wide programs.

Local Health Hubs – Local Health Hubs will be comprised of health service providers in and around specific communities. The local hubs will plan and provide health care services based on the unique needs of their community, to meet the health care needs of the population they serve and to support individuals in accessing care as close to home as possible.

Integrated District Networks – Integrated District Networks, where multiple communities share services, will include representation from Local Health Hubs, the North West Community Care Access Centre and an acute care hospital designated as a District Health Campus. The District Health Campus will provide specialist care to patients in the district through its site or through visiting clinics and/or technology. The Integrated District Networks will focus on providing equitable access to health care services for the residents within the district, improving health outcomes for the population and arranging for people to receive the level of care they need close to home.

Regional/LHIN-Wide – Regional programs and services will ensure care is based on evidence and leading practice and will set the standards of care across the LHIN. Expertise and economies of scale will be leveraged through the development and delivery of complex, high impact specialty programs/services across the LHIN. The regional program or service may be led by a community or hospital provider, depending on the area of expertise. The regional program or service provider will have responsibility and accountability to work closely with the Integrated District Networks to disseminate best practices close to home.

The Vision

The Health Services Blueprint was designed to help the North West LHIN realize a vision for health care that will truly put patients at the centre of the system. This is a complex, transformational change initiative that will redefine the health care system in the Northwest with a renewed focus on improving the patient experience and creating a sustainable health system built around the population's health needs. Success of this model will be dependent on harnessing the power of partnerships throughout our region to improve the health outcomes of our population. Opportunities exist to leverage technology to further expand community services, telemedicine, telehomecare, and electronic health records to deliver seamless, inter-professional care as close to home as possible.

By informing better decisions over the next 10 years about allocating health care resources, shifting resources from hospital to community and managing the growing population of individuals with multiple chronic diseases, the Health Services Blueprint recommendations will help lower the number of emergency department visits and improve access to care and delivery of services in the community. The Health Services Blueprint will also provide direction for creating a better integrated health care system in the Northwest, which patients can count on to deliver the right care, at the right time, in the right place – closer to home.

Our LHIN, Our People

Looking back over the past 12 months there has been progress in creating commitment to change as we build the model for an integrated health care system in the North West LHIN. However, to properly evaluate what has been accomplished, it is first necessary to understand the geography of the region and the people who live here.

The North West LHIN is vast. It covers 47% of Ontario's total land mass. Our boundaries extend east from the Manitoba border to just west of White River, and from Hudson Bay in the north to the United States border in the south. At the same time, however, this immense region is home to only 2% of Ontario's population.

According to the recently released 2011 Statistics Canada Census data, the population of the North West LHIN is approximately 222,000 people. However, 13 First Nations communities did not participate in the 2011 Census – and these communities accounted for approximately 8,000 people in 2006.

Our population density of 0.5 people per square kilometre is the lowest in the province.

Communities in the North West LHIN are spread across almost 458,010 square kilometres, which makes planning and delivery of health services within the Northwest very challenging. This is compounded by the fact that many of the communities are in remote areas with road access only in the winter; others are accessible only by air year-round.

The Vast Area We Serve

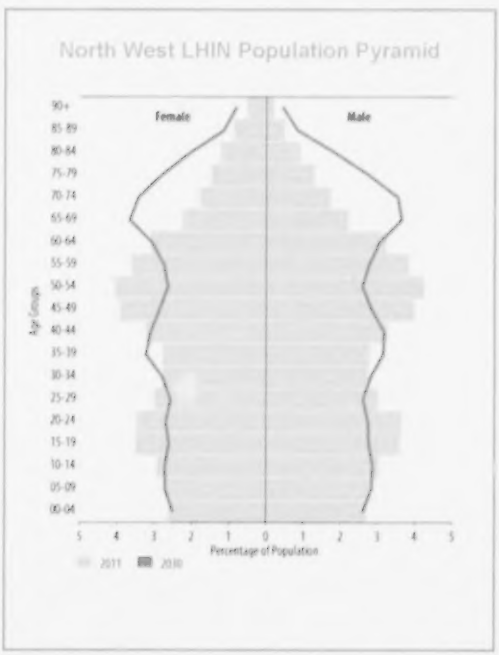
* The **Municipality of Greenstone** is an amalgamation of the former townships of Beardmore and Nakina, the towns of Geraldton and Longlac, and the communities of Caramat, Jellicoe, Orient Bay and MacDiarmid. The catchment area also includes the following First Nations communities: Long Lake #58, Ginoogaming, Rocky Bay, Sand Point, Lake Nipigon Ojibway (Animbiigoo-Zaagi'gan Anishinaabek), Poplar Point First Nation, and Aroland First Nation.

Our Population

Like most jurisdictions, the North West LHIN has a population that is growing older. But unlike other areas, the number of people living in this region is shrinking. According to the new Census data for 2011[3], the North West LHIN's population has decreased by 5.3% between 2006 and 2011.

According to the Ministry of Finance 2006 Census population projections, the North West LHIN's population for 2010 was estimated to have been 238,769. Between 2011 and 2030, the Ministry of Finance projects our population to slightly decline by a further 0.7% to 235,807 by 2030. These projections will likely be adjusted based on the current 2011 census data. Notably the North West LHIN is projecting a 79% increase in seniors (age 65 and over) living in the North West LHIN between 2011 and 2030.

The Population Pyramid graph below illustrates the shift in the population from younger to older age groups.



[3] The only available 2011 census data is for total population.

The following bullet points highlight some of the unique census characteristics in the North West LHIN census population[4] based on 2006 data[5].

- 19.2% of those in the Northwest self-identify as Aboriginal. This is the highest of the 14 LHINs and much higher than the provincial average of 2.0%.
- Of the North West LHIN residents who self-identify as Aboriginal, 15.3% are North American Aboriginal and 3.4% are Métis. However, we know this population is underrepresented in the census data.
- In the 2006 Census, the median age for Ontario residents reporting Aboriginal identity was 28 years compared to 38 years for non-Aboriginal residents[6].
- The proportion of residents who are Francophone is slightly lower than the province as a whole (3.5% versus 4.4%).

Within the North West LHIN, there are variations between sub-LHIN areas and communities.

Table 1 on page 12 highlights some of the variation in census population characteristics of sub-LHIN planning areas across the North West LHIN.

[4] Statistics Canada Census, 2006

[5] 2011 census characteristics information not yet available

[6] First Nations Peoples in Ontario: A Demographic Portrait. Health Analytics Branch. Jan. 2009

Table 1: 2006* Census Characteristics of North West LHIN Sub-LHIN Planning Areas

2006 Census Indicators	North West LHIN Sub-LHIN Planning Areas				
	Kenora District Area[1]	Rainy River District Area	Thunder Bay City (& Surrounding Area)	Thunder Bay District Area	North West LHIN
Population[1]	64,465[1]	21,565	122,905	26,155	235,095
% population age 65 and over	11.4%	16.1%	16.0%	11.4%	14.3%
% Population of Aboriginal Identity[2]	38.4%	21.7%	8.3%	19.9%	19.2%
% French-Speaking population	2.5%	1.7%	2.8%	10.8%	3.5%

Notes:

* 2011 Census data not yet available.

[1] Sub-LHIN area census analysis prepared by Health Analytics Branch, MOHLTC, August 2008 has been revised.

[2] Estimates of Aboriginal population in sub-LHIN planning areas have not been adjusted with INAC data.

While the proportion of seniors in the North West LHIN is increasing and the overall population is beginning to decrease, this is not the case with the Aboriginal population. The Aboriginal population in the North West LHIN is growing, and the population is younger[7].

- 50% of the Aboriginal population in Kenora is under the age of 25, almost double that of the non-Aboriginal population, where 27% are under the age of 25.
- The Aboriginal population living in the Kenora area is young and growing. In 2006, 2,365 Aboriginal people lived in Kenora, a 40% increase from 2001.
- 48% of Aboriginal people living in Thunder Bay are under the age of 25, compared to 28% of the non-Aboriginal population.
- The Aboriginal population living in the census area of Thunder Bay is also younger and growing. In 2006, 10,055 Aboriginal people lived in the area of Thunder Bay, a 23% increase from 2001.

[7] 2006 Aboriginal Population Profile for Kenora and 2006 Aboriginal Population Profile for Thunder Bay. Statistics Canada. 2009

Population Health Profile

According to the 2009-10 Canadian Community Health Survey of the North West LHIN for residents age 12 and over, the data shows:

- 57.4% of our residents report their health as "excellent" or "very good" compared to the provincial rate at 61.0%.
- 68.2% report their mental health as excellent or very good in the Northwest which is lower than the provincial rate at 74.3%.
- 23.9% of residents age 12 and over who report being current smokers is significantly higher than the provincial estimate of 18.9%.
- 20.9% of those who drink regularly consume five or more drinks on one occasion at least once a month over past year which remains significantly higher than the rest of the province at 16%.
- 58% of residents in the North West LHIN report being physically active during leisure time which is higher than the province at 50.5%.
- 61.7% of residents age 18 and over report being overweight or obese (based on self-reported height and weight) which

continues to be higher than the province at 52.0%.
- 21.5% of 12-to-17 year olds in the North West LHIN were obese or overweight in 2009/10, slightly different than the provincial estimate of 20.5%.
- 83.5% of residents age 12 and over who report having a regular medical doctor is significantly lower compared to the province at 91.1%.

Based on the most recent mortality data (2005 to 2007), the differences between North West LHIN residents and all Ontarians include:

- Significantly higher mortality rates for North West LHIN males for all causes combined at 761.6/100,000 males compared to provincial rates at 640.8/100,000 males.
- Higher rates of circulatory system disease for males at 234.2/100,000 compared to the provincial rate of 197.1/100,000.
- 1.7 times higher male mortality rates in Northwestern Ontario for unintentional injuries at 52.5/100,000 males compared to the provincial rate of 31.6/100,000 for males.
- 2.3 times higher suicide and self-inflicted injuries for males at 27.7/100,000 compared to the provincial rate of 11.9/100,000 for males.
- Significantly higher mortality rates for females in the North West LHIN for all causes combined at 518.4/100,000 compared to the provincial rate of 430.2/100,000.
- Higher circulatory system disease for females in the North West LHIN at 138.9/100,000 compared to the provincial rate of 122.9/100,000.
- 1.6 times higher female mortality rate due to unintentional injuries at 26.6/100,000 females compared to the provincial rate of 16.1/100,000.
- 3.4 times higher suicide and self-inflicted injuries for females in the North West LHIN at 13.5/100,000 compared to the provincial rate of 3.8/100,000.
- Significantly lower breast cancer mortality rate for females in the North West LHIN at 15.5/100,000 females compared to the provincial rate of 22.0/100,000 females.

Aboriginal Health

Based on the Canadian Community Health Survey (combined years 2005, 2007-08), some significant differences in health status and health behaviours exist provincially between Aboriginal and non-Aboriginal populations age 12 and over:

- 52% of Aboriginal people perceived their health as very good or excellent, compared to 61% of non-Aboriginals.
- 66% of Aboriginal people perceived their mental health as very good or excellent, compared to 75% of non-Aboriginals.
- 40% of Aboriginal people reported being a current smoker. That is double the 20% of non-Aboriginals who smoke.
- 23% of Aboriginal people reported heavy drinking (five or more drinks on one occasion at least once a month over past year), compared to 16% of non-Aboriginals.

Francophone Health

Based on the combined years of the Canadian Community Health Survey (2005 & 2007), the following estimates are reportable for North West LHIN Francophones age 12 and over:

- 55% of the Francophone population age 12+ perceive their health as very good or excellent.
- 67% perceive their mental health as very good or excellent.
- 63% report having a regular primary care physician, which is significantly lower than the 85% of non-Francophones in Northwestern Ontario who have a family doctor.

Number of Health Care Facilities and Programs Funded by the North West LHIN

During the 2011/12 fiscal year, the North West LHIN was responsible for funding the following:

Community Care Access Centre	1
Community Health Centres (1 with 2 satellites)	2
Community Mental Health and Addictions Services	36
Community Support Services	64
Long-Term Care Homes	15
Hospitals	13
Total number of Health Service Provider (HSP) programs or operations	131
Total number of HSP organizations	97*

*Note: This represents the number of individual Health Service Providers (HSPs) funded by the North West LHIN. Some HSPs funded by the North West LHIN provide service in multiple sectors but are only counted once for the purpose of this report.

Advancements in the Health System in 2011/12

Integrated Health Services Plan (IHSP) 2010-2013

Every LHIN in Ontario is guided by an *Integrated Health Services Plan* (IHSP), which provides an assessment of local health care needs and existing health services, identifies priorities for health system improvements, and sets out plans to address these priority health care issues. The North West LHIN is currently in the second year of its *Integrated Health Services Plan (IHSP) 2010-2013*. This multi-year plan builds on the findings and accomplishments of the LHIN's first IHSP, which guided activities from 2007 to 2010.

The planning priorities are informed by significant community engagement, as well as through rigorous data collection, interpretation and analysis. Our 2010-2013 IHSP II identifies 11 local and provincial priorities, which can be broken out across three main areas:

Access to and Integration of Services
Emergency Department Wait Times & Alternate Level of Care
Primary Care
Specialty Care & Diagnostic Services
Chronic Disease Prevention and Management
Long-Term Care Services
Mental Health & Addictions Services

Enablers
Health Human Resources
eHealth
Integration of Services along the Continuum of Care

People of Northwestern Ontario
Aboriginal Health Services
French Language Health Services

Much progress has been made in each of the priority areas through the hard work and dedication of our health service providers.

Examples of the changes that we are making to continually improve health care for the people of Northwestern Ontario are summarized in this report under each of our four Strategic Directions – to illustrate how our Strategic Plan is advancing.

Strategic Direction: Improved health outcomes resulting in healthier people

Through the Emergency Department Wait Times & Alternate Level of Care Strategy, emergency wait times are reduced and people receive the right level of care.

This past fiscal year, the North West LHIN invested more than $8.1 million in 40 different initiatives across the region. The initiatives were designed to improve access to community-based health services, avoid unnecessary visits to the emergency department, lower hospitalization rates and expedite discharge from hospital.

Alternate Level of Care (ALC)
Over 2011/12 the North West LHIN actively engaged and worked with stakeholders to implement the *Home First* philosophy with the goal to achieve a reduction in Alternate Level of Care days[8]. As a result, the North West LHIN saw a 4.3% decrease in the ALC rate, moving from 22.67% in Q3 2010/11 to 18.78% in 2011/12. During the second quarter of 2011/12, the ALC rate decreased to 15.3%, exceeding the

[8] Alternate Level of Care (ALC) days refer to the number of days that a patient spends in hospital, when he or she has completed an acute care episode and could receive more appropriate care in the community. Reducing ALC days is a top priority of the Ministry of Health and Long-Term Care and the North West LHIN.

LHIN performance target for the first time since this indicator was introduced.

One of the drivers of ALC days in the North West LHIN is the situation facing many of the small rural communities, where there is limited access to after-hours primary care and limited community support services such as supportive housing, assisted living, homemaking and transportation options.

Further the current ALC definition does not effectively capture the situation in rural/remote communities, where the hospital is the only option for most kinds of care (rehabilitation, complex continuing care, convalescence, and palliative care). Bed occupancy rates at small community hospitals are lower, and the challenges related to ALC do not create the same pressures as seen in larger centres in Kenora and Thunder Bay.

In 2011/12, the North West LHIN, in partnership with the health service providers, continued implementation of multipronged initiatives to address the ALC issue as listed below:

- Created 3,650 annual placement days through the funding of 10 interim long-term care beds in Kenora.
- Implemented Assess & Restore Programs in Thunder Bay, Kenora, Dryden and Sioux Lookout.
- Increased investment in the Nurse-Led Outreach program in Thunder Bay. This program:
  - Conducted 660 assessments of residents living in nursing homes in Thunder Bay.
  - Decreased the number of transfers from long-term care to the emergency department by 40%.
  - Decreased the number of hospital admissions from long-term care by 60% in the third quarter of 2011/12.
- Increased funding to the Red Cross for home maintenance and housekeeping services in Thunder Bay.
- Increased funding for the provision of homemaking services offered by the North West Community Care Access Centre (CCAC) through the Wait at Home and Intensive Case Management programs.
- Initiated the expanded role of the North West CCAC in the assessment and placement of individuals into adult day programs and supportive housing services across our region.
- Increased regional respite services offered by Wesway, converting $700,000 in pilot project funding to permanent base funding.
- Overall invested an additional $1,056,000 to support *Home First* in Thunder Bay and Kenora.

Home First

Home First was launched in September 2010. The initiative is a philosophy of care rather than a program. *Home First* introduces a new way of thinking and approach to patient-centred care. What *Home First* seeks to change is the long-established pattern of having older patients remain in hospital or get placed directly into long-term care, when in fact, with the right community supports in place, their health care needs could be addressed at home.

With the *Home First* approach, health care providers in the hospital work together with Community Care Access Centre case managers and other health system partners in the community to explore all possible patient discharge options for safe transition to home. Successes include:

- A 21% reduction in ALC patients in hospital from September 2010 to February 2012 at Thunder Bay Regional Health Sciences Centre.
- A 25% reduction in ALC patients waiting in hospital in the post-acute care setting of St. Joseph's Care Group.
- An 8% reduction in ALC patients waiting in hospital from November 2011 to February 2012 at Lake of the Woods District Hospital.
- A 23% reduction in the total number of ALC patients in the City of Thunder Bay since October 2010.
- Shorter number of ALC days for patients waiting for rehabilitation, complex continuing care and long-term care.
- A 10.7% decrease in the number of patients on the long-term care wait list in the North West LHIN between July 2010 and July 2011, (532 to 475 individuals).
- A 39% reduction in the number of individuals waiting in hospital for long term care between July 2010 to July 2011.

Improving Emergency Department (ED) Wait Times

The North West LHIN is heavily reliant on locum coverage for emergency departments across our region. Given our vast geography, access to emergency department services is a priority for the North West LHIN. In 2011/12, the North West LHIN continued advancing the recommendations of the *North West LHIN Regional Emergency Department Study* as follows:

- Implemented common evidence-based order sets for admitted patients in community hospitals outside of Thunder Bay.
- Developed an eCredentialing model with all 13 hospital sites participating in the process. This innovative project will reduce the time it takes to process physician credentials.
- Completed a review of current practices related to non-urgent medical transportation.
- Supported recruitment of emergency department locums for regional hospital sites.

We also made significant strides in streamlining and standardizing triage, admission and coding practices across the Northwest region. This has resulted in improved reporting of the level of acuity of patients seen in the emergency departments and measurement of emergency department wait times across our region.

North West LHIN Fact – In 2011/12, 93% of non-admitted patients were discharged from the emergency department within the provincial standard of eight hours.

Through the Emergency Department Pay-for-Results (P4R) Program, which is aimed at improving the flow of patients and reducing ED wait times, Thunder Bay Regional Health Sciences Centre has:

- Reduced emergency wait times for admitted patients by 5.7% from 31.6 hours in 2010/11 to 29.8 hours in 2011/12.
- Improved ED wait times for both low and high acuity patients (6.7 hours and 4 hours respectively) – one of the best performers in the province.
- Discharged more than 93% of non-admitted patients from the emergency department within the provincial standard of eight hours.

Through the Provincial Mental Health & Addictions Strategy, services will be evidenced-based, coordinated and provide opportunities for recovery.

In 2011/12 the Ontario government introduced a comprehensive 10-year Mental Health and Addictions Strategy titled *Open Minds, Healthy Minds* with the first three years of this strategy focused on Child and Youth services.

One of the initiatives under the strategy was implementation of 18 Service Collaboratives led by the Canadian Mental Health Association. Service Collaboratives bring together service providers from different organizations to plan and deliver a seamless continuum of care for people with mental health and addiction issues in a region or community: for example transitions in care between child/youth and adult services. Thunder Bay is one of four sites in the province to establish a Service Collaborative.

The three-year pilot of the Getting Appropriate Personal and Professional Supports (GAPPS) program concluded and is now permanently funded due to its success. Visits to the emergency department by people enrolled in GAPPS declined by 65% and, even after discharge from the program, ED visits were down by 27%. *(see box page 18)*

Integrating care and sharing of common assessment tools

The North West LHIN is advancing the use of the Ontario Common Assessment of Need (OCAN) tool with service providers to better

serve clients with mental health and addictions issues.

Through the self-assessment tool, patients have a more active role in their service planning. The service providers working with the patient are able to securely share the patient's information and, together, provide a more comprehensive plan of care. Use of the OCAN tool will spread to an additional 15 health service providers across the Northwest in early 2012/13.

Behavioural Supports Ontario
The Behavioural Support Ontario (BSO) Project announced in 2011/12 was created to enhance services for older Ontarians with complex and "responsive" behaviours, such as aggression and wandering, for individuals wherever they live – at home in the community, hospital or in long-term care. This is an important initiative given that more than 10% of the current senior population in the North West LHIN has Alzheimer's disease and related dementia. The North West LHIN will advance the provincial Behavioural Supports Ontario (BSO) program through implementation of the local plan over the next year.

About GAPPS

GAPPS is a collaborative outreach program, involving the St. Joseph's Care Group, Canadian Mental Health Association, Alpha Court and the NorWest Community Health Centre. The program was created to respond to the frequently unmet needs of people with serious, unstable and complex mental illness and addictions issues.

Workers engage with people who require, but are having trouble accessing, health and social services. Individuals are provided assistance and support in navigating the various health, mental health/addictions and social services and housing that are available in the Northwest.

Kane's Story
'Kane' lived on the streets for many years. He slept on park benches, visited food banks, and pushed a shopping cart filled with all his belongings. He came from another country and struggled with mild language barriers. The GAPPS outreach team reached out to Kane, first with brief conversations, then through regular engagement. It determined that his principal need was food. Initially, Kane did not want help with anything else, but after a few months he decided he wanted help in obtaining identification, finances, and housing. The GAPPS team maintains contact with Kane who now has a higher quality of life shaped by his individual needs and understanding.

Access to Primary Health Care is enhanced to keep people healthy

Primary care is one of the first points of contact that patients have with the health care system. Whether it is with a family physician or nurse practitioner, that first encounter is of tremendous importance as it lays the groundwork for whatever other steps might be required on a particular person's health care journey.

North West LHIN Fact – Approximately 22,000 people in the Northwest do not have access to a primary care provider – that is the highest number of unattached patients, per capita, in Ontario.

The LHIN continues to support the North West Community Care Access Centre's Health Care Connect initiative. This innovative provincial program provides unattached patients an option to self-refer and register with the program and receive support to access a local primary care provider. To date, the program has linked 39% of applicants with a primary care provider – more than 2,500 individuals who previously did not have access to primary care.

In January 2012, the LHIN hired a Primary Care Physician Lead whose role is to help improve linkages and access to primary care health services in the community. One of the Lead's goals is to engage the primary care sector about opportunities to reduce readmission rates to hospital for conditions that could be better managed in the community. This work will be done in collaboration with local primary care providers, including the Family Health Teams, Nurse Practitioner-Led Clinics, and Community Health Centres in the Northwest.

Innovative primary care solutions are already underway in the Northwest. For example, the NorWest Community Health Centres' mobile unit provides diabetes care and has now expanded services to include wound

management for people in under-serviced areas who are at high risk of developing diabetes.

The eHealth Strategy helps streamline health information and make it more accessible. This enhances safety, decision-making and patient satisfaction.

Advancing eHealth and improving access to high quality health care

One of the most important goals for health care in the 21st century is developing comprehensive, dependable electronic health information. Most jurisdictions are working toward preparing their health care systems for the day when every citizen has an interoperable Electronic Health Record (iEHR). The Ontario government is implementing a comprehensive provincial eHealth strategy. The North West LHIN is working closely with eHealth Ontario, other LHINs and local health services providers to ensure that health care in our region keeps pace with that strategy.

Excellent progress was made on eHealth this past year in the Northwest and across the province. eHealth Ontario released Ontario's eHealth Blueprint in the fall of 2011, and the North West LHIN eHealth team worked on a broad range of innovative projects designed to improve access to high quality health care right here, close to home, while at the same time advancing the provincial plan.

The North West LHIN, in partnership with North East LHIN, Champlain LHIN and South East LHIN, is participating in the Connecting Northern and Eastern Ontario (cNEO) project. This $37 million project is funded by eHealth Ontario, together with the partner LHINs, and will provide health service providers with timely and secure access to patient health information at any point of care – hospitals, primary care and community care - throughout the cNEO region. The project involves the planning and implementation of key pieces of technology that collect and store information and enable health care professionals, such as physicians, pharmacists and nurses, to quickly and easily view patient information in a seamless and uniform manner. The cNEO project will improve the quality and safety of health care, the patient and clinician experience, and will improve the transitions patients make between care providers.

Another project that provides secure, timely access to a patient's health information is the Doorways project. The North West LHIN, along with the North East, Champlain and North Simcoe Muskoka LHINs, worked with Ontario's Community Care Information Management (CCIM) program to set up a portal that allows clinicians to securely share and access mental health assessment information electronically. This provides better integrated care to patients and allows health service providers to respond quickly to their needs.

Electronic Medical Records (EMRs) are a modern-day version of the doctor's filing cabinet. Instead of bulky paper files, they contain patient information electronically - including medical and medication history, x-ray and lab results – and assist with office work such as billing, scheduling, ordering tests and generating prescriptions. As of September 2011, approximately 61% of family physicians in the North West LHIN were using electronic medical records – the third highest rate in the province. The integration of EMRs with hospital information is a tremendously important step in electronically connecting and integrating the health care system. Information now flows seamlessly between 12 hospitals and 27 clinics in our region.

The information highway gets faster and more efficient

In 2011/12, more than 250,000 reports were electronically transmitted from hospitals to clinician EMR systems in the Northwest. The benefits are significant: paper and delivery costs are reduced, clinical health information is provided to health providers in a timely and efficient manner, and better service is provided to the patient.

Other eHealth initiatives aimed at improving access to care, quality and safety of care, and the patient and clinician experience include:

- The eHealth Ontario OneMail email system, which enables the secure transmission of email between participating organizations, was implemented by three additional organizations in our region. There are now nine sites using OneMail in the Northwest including hospitals, Nurse Practitioner-Led clinics, mental health and addictions agencies, and community support services.
- Nine more hospitals are connected to the Ontario Enterprise Master Patient Index (EMPI) provincial system. EMPI provides unique identification of patients regardless of where in the province they receive care. All hospitals in the North West LHIN are now participating in the system.
- An EMR system for the regional cancer program was set up. This system provides a centralized paperless patient chart for everyone who is receiving cancer treatment in the North West LHIN and the information is instantly available to all authorized clinicians. This $4 million project was funded by Canada Health Infoway, which contributed just over $2 million. The balance was provided by the Regional Cancer Centre North West.
- The Kenora Chiefs Advisory, an alliance of independent participating First Nations in the western region of Ontario, is implementing a groundbreaking patient database for the Aboriginal communities they serve. The database, which is being created with investment and support from the North West LHIN, Health Canada and eHealth Ontario, will contain important patient information about the Aboriginal population in the region. The first of its kind in Ontario, it will become a fundamental piece of electronic health records in Northwestern Ontario and will improve health care delivery in participating communities.

Health Human Resources

In 2011/12 the LHIN provided funding for 28 nursing positions to work in the area of telemedicine. It is expected that this expansion of an already highly successful program will result in approximately 10,000 additional clinical telemedicine visits per year for the people of Northwestern Ontario.

New Investments in Telemedicine

Telemedicine can be described as the delivery of health care services using information and communications technology. A patient in one location is able to consult with a specialist in another, using video monitors that allow the two to see and hear one another in real time, regardless of how far apart they might be.

The role of nurses during these remote consultations is critical. They provide support to patients at the "host" site, operate the equipment, help patients in the diagnostic and assessment phase, and facilitate communication with the specialist at the other site.

Telemedicine Nurse's Story

A Thunder Bay woman had a meeting in the fall with a specialist in Toronto for what she calls a relatively serious medical issue. Her follow-up consultations in January and February were done via telemedicine. She says that saved her time and money, lowered her stress level, and thanks to the telemedicine nurse who was on hand, it seemed almost exactly like a real face-to-face appointment.

"If you think about what nurses do whenever you go to a clinic, that's what they do in a telemedicine consultation. They make sure everything works. They make sure you're comfortable, and that you understand what to expect. When it's done, they make sure you understand everything the doctor said to you. They make sure the human side of the appointment is not lost," the woman says.

Strategic Direction: Improving the Patient Experience through Continuous Quality Improvement

Care delivery is centered on patient needs and experience; is evidence based and patients transition seamlessly across levels of care

Integration of Services Along the Continuum of Care

The North West LHIN continues to pursue integration opportunities and promote better coordination of care and improve access to health care services across our region. The most significant opportunity for integration comes with the announcement and release of the *North West LHIN Health Services Blueprint: Building our Future*, detailed at the start of this report.

Over the past year the North West LHIN has supported the advancement of the expanded role of the Community Care Access Centre (CCAC). The North West CCAC is now assessing and determining eligibility for services and coordination for placement of individuals into:

- Adult day programs
- Supportive housing services
- Long-term care
- Through *Home First*, joint discharge planning with hospitals and other key stakeholders in our region.

The North West LHIN-Wide Falls Prevention Program, involving 32 health service providers, achieved some excellent results in falls reduction in some of the long-term care homes over the past few years. This program was initially integrated with Health Care Quality's *Residents First* program. Building on the success of our falls prevention program, an Integrated Provincial Falls Prevention initiative has now been introduced which encompasses a broader partnership between the LHIN and the two public health units in the Northwest region. Through this initiative, the number of falls will be reduced, the quality of life for Ontario seniors aged 65 years will improve and health system costs will be reduced.

Better Chronic Disease Prevention and Management prevents hospitalization

Management of chronic diseases is a vital component of any sustainable health care system. In 2011/12 the North West LHIN, through the Health Services Blueprint, identified several high impact clinical conditions – such as diabetes, congestive heart failure and cancer – that result in higher admission rates to hospital. The North West LHIN is working closely with health service providers to change the system by shifting the care model and moving from reliance on inpatient care to outpatient community-based care.

Both provincially and within the North West LHIN, diabetes is a key area of focus. In 2011/12, the LHIN took several positive steps to bring about better outcomes for people with diabetes. These include:

- Improved access to primary diabetes care, including wound management, for over 200 people.
- Established an acute centre for diabetes care which received over 400 referrals in the first year of operation.
- Expanded the acute centre for diabetes care at the Sioux Lookout Meno Ya Win Health Centre campus to serve 100 people.
- Improved screening for people with diabetes through the Baseline Diabetes Dataset Initiative, which is a tool that lets physicians know if their patients with diabetes are getting the tests they need to manage their disease.

Additionally the North West LHIN successfully:

- transitioned the chronic disease self-management program to the North West CCAC.

- Expanded access to primary care services for people with congestive heart failure and chronic obstructive pulmonary disease through an innovative evidence-based telehomecare program.

Innovative Regional Telehomecare Programs Reduce Readmission to Hospital

Two unique programs designed to better support people in managing their chronic conditions at home were implemented at Thunder Bay Regional Health Sciences Centre in 2011/12. People living with congestive heart failure and chronic obstructive pulmonary disease are the focus of this initiative.

Individuals are supported at home in the community by an interprofessional care team made up of a nurse practitioner, a pharmacist and a respiratory therapist. Additionally, individuals are connected to the health care team through devices that are linked to the telephone line. The equipment was supplied by the Ontario Telehealth Network.

Emerging evidence suggests that there is a reduction in readmission rates to hospital for individuals with congestive heart failure and positive benefits to individuals living with these chronic diseases through improved quality of life.

A Patient's Telehomecare Story

An elderly Thunder Bay woman with congestive heart failure is enrolled in the Telehomecare program. She speaks little English and has trouble interacting with the health care system. Her daughter, who is her primary caregiver, says the program has changed their lives.

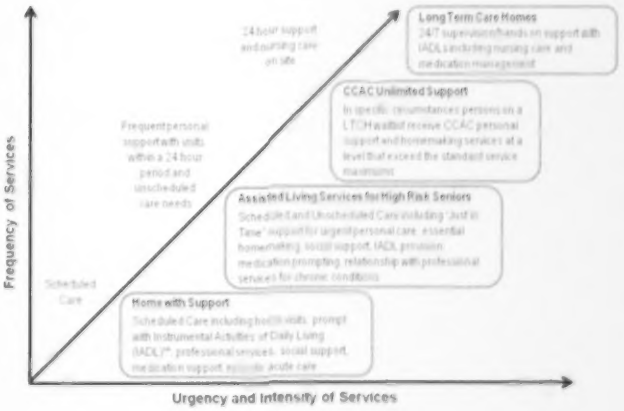
"This program is a lifeline for us. We send all of my mother's vital information, like blood pressure and temperature, through the phone. If there is a problem, the nurse practitioner will call us right away. We feel in control, which we never did before. Instead of running to the hospital, we know what to do because we know what's going on," the daughter says.

Patients transition seamlessly across levels of care

Building a continuum of care for Long-Term Care Services

One of the significant challenges faced by the North West LHIN is its rapidly aging population. Between 2010 and 2030, the number of seniors in the North West LHIN is expected to increase by 85% for those aged 65-74 and by 62% for those aged 75 and over. At the same time, the number of people younger than 65 is expected to decrease by 10%. In addition, 32% of seniors in the region live alone, compared to 25% provincially.

Seniors have told us they want to stay at home as long as possible. The LHIN offers a number of long-term care services along the continuum of care to help maintain seniors in the community. Community supports include meals on wheels, social and congregate dining, homemaking, home maintenance, transportation and respite. Further, the North West LHIN has identified assisted living services for high risk seniors as an integral part of the continuum of care *(see graphic below)*.



The North West LHIN focused its investments for seniors in three areas: additional community support services such as respite services in Thunder Bay and the Districts of Kenora and

Rainy River; additional assisted living services such as the addition of 39 new supportive housing units/service in Kenora, Rainy River and Dryden; and new capacity in long-term care such as the addition of 10 interim long-term care beds in Kenora and 22 long-term care beds in Terrace Bay.

The North West LHIN will continue to invest in community-based supports across the region.

Strategic Direction: Access to health care that people need, as close to home as possible

Achieving Wait Time targets in Ministry of Health and Long-Term Care priority areas

Improving Access to Specialty Care & Diagnostic Services

During 2011/12, the North West LHIN performed very well with wait times among the lowest in the province in the following areas:

- Cancer surgery wait times decreased to 37 days compared to the LHIN target of 45 days and the provincial target of 82 days.
- Cataract surgery wait times decreased to 103 days compared to the LHIN target of 112 days and the provincial target of 182 days.

The LHIN experienced increased wait times in 2011/12 for hip and knee replacement.

- Wait times for hip surgery increased from 178 days to 187 days compared to the provincial target of 182 days.
- Wait times for knee replacement surgery increased from 194 days to 216 days compared to the provicial target of 182 days.

This increase was primarily driven by patients who elected to wait for their surgery. During the year, the LHIN initiated work with the Regional Joint Assessment Centre to identify strategies to increase referrals to the first available surgeon.

In the area of diagnostic imaging, the LHIN saw:

- An increase in wait times for Magnetic Resonance Imaging (MRI) from 66 days to 78 days compared to the provincial target of 28 days.
- An increase in wait times for Computerized Tomography (CT) scans from 25 days to 40 days compared to the provincial target of 28 days.

The increase in MRI wait times relates to a 4.5% reduction in Wait Times Strategy funding. Despite the increase in wait times for MRI scans, the North West LHIN's MRI wait times remain among the best in the province.

CT wait times increased due to loss of capacity in the system. The main clinical CT scanner at Thunder Bay Regional Health Sciences Centre was replaced with a more modern and efficient scanner.

The people of the Northwest are engaged in identifying and planning for their health needs

Community Engagement

We understand that if we are to manage health care in such a way as to reflect local priorities and meet local needs, we need to continuously strive for increased engagement with stakeholders at a local level.

Much of our engagement process was focused on the Health Services Blueprint. In all, we engaged 6,705 individuals over the course of 880 sessions across the Northwest including forums, roundtable discussions, meetings, workshops and training, and surveys. Participants in these sessions reflected the vast but interconnected nature of our health system. They included: community members and leaders, educators, municipal, provincial and federal government officials, other ministries and jurisdictions as well as other funding agencies.

Culturally-Appropriate Care

The North West LHIN has developed a Cultural Competency Toolkit with specific indicators to measure how diversity is applied within an organization. The toolkit will be made available to health service providers across the region and will support organizations in assessing their ability to provide culturally- appropriate care for the patients they serve.

Engaging Aboriginal Health Service Providers

The North West LHIN meets with Aboriginal Health Directors from 69 First Nations twice each year. The focus of engagement this year was on mental health and addictions, and addressing the related issues and challenges in their communities. The information gathered will help inform our Mental Health and Addictions Strategy.

Engagement with broader stakeholders to address the needs of Aboriginal Communities

For the first time, the North West LHIN worked with Emergency Measures Ontario and our health service providers and partners to coordinate health care services for evacuees. Over 3,000 people were evacuated from small, rural and remote First Nation communities due to the smoke and threat of forest fires in Northwestern Ontario last summer.

In November, the LHIN hosted a mental health and addictions forum titled "Better Together – Minosamiigut gii wii doo kadiing." This forum brought together Aboriginal and non-Aboriginal health service providers to discuss the serious challenges facing the Northwest region related to mental health and wellbeing. Six priorities were identified by the participants and these will be used to inform our Mental Health and Addictions Strategy

In 2011/12, the LHIN engaged 633 participants from 68 Aboriginal communities and 95 organizations across the region. LHIN personnel emerged better informed about community health planning priorities and challenges faced by Aboriginal communities such as mental health and addictions, the need for long-term care services and better chronic disease prevention and management. The North West LHIN will use this information in the development of strategies under the Integrated Health Services Planning priorities.

Engaging with Francophones to improve access to French Language Services

The North West Local Health Integration Network has made progress in improving the integration of French language services within the local health care system. Important steps were taken the past year to improve access to health services for the Francophone population. Health service providers worked with the LHIN to prepare a French Services Plan to better meet the needs of this population in Northwestern Ontario. This work is ongoing.

Strategic Direction: Well-managed resources where value for the dollars invested is achieved

Ministry-LHIN Performance Agreement

The North West Local Health Integration Network (LHIN) and the Ministry of Health and Long-Term Care have negotiated an agreement which defines the obligations and

responsibilities of both the LHIN and the Ministry for the period 2011/12.

The agreement includes a number of schedules which outline how the LHIN is to carry out activities related to areas such as Community Engagement, Planning and Integration, Local Health System Management, Financial Management and Local Health System Performance and eHealth.

This type of agreement is mirrored in the accountability agreements that LHINs have negotiated with health service providers such as hospitals, multi-sector agencies and the long-term care sector.

Report on MLPA Performance Indicators

The Ministry-LHIN Performance Agreement (MLPA) for 2011/12 sets out performance indicators and performance targets for the local health system. The North West LHIN works with health service providers to achieve the targets.

In addition to the details provided on wait times performance related to ALC *(on page 15)*, emergency department wait times *(on page 17)* and surgeries and diagnostics *(on page 23)*, in 2011/12 the North West LHIN:

- Decreased wait times from 37 days to 35 days for clients requiring CCAC services in the community.

  This improved response time is linked to the increased investment in community services under the *Home First* initiative.

- Saw continued improvement in the area of hospital readmission rates.

  The readmission rate for select case mix groups decreased from 17.58 to 16.86%. This improvement is also linked to the success of implementation of the *Home First* Philosophy.

- Realized improvements in the area of emergency department utilization for patients with mental health and addictions-related conditions.

  The rate of repeat visits for mental health and addictions decreased to 15.78% and 26.58% respectively. These improvements are attributed to targeted LHIN and Ministry investments in direct service enhancement, increased nursing staff and expanded telemedicine capacity.

Table 2 on page 26 outlines the indicators measured in the North West LHIN in 2011/12.

The data for Table 2 is dated as follows:

1. Cancer Surgery WT – Q4 2011/12
2. Cataract Surgery WT – Q4 2011/12
3. Hip Replacement – Q4 2011/12
4. Knee Replacement – Q4 2011/12
5. MRI Scans – Q4 2011/12
6. CT scans – Q4 2011/12
7. ALC – Q3 2011/12
8. ER LOS for admitted patients – Q4 2011/12
9. ER LOS non-admitted high acuity patient – Q4 2011/12
10. ER LOS non-admitted low acuity patients – Q4 2011/12
11. Repeat ED visits for MH –Q2 2011/12
12. Repeat Ed visits for SA – Q2 2011/12
13. Readmission rates for select CMG's – Q2 2011/12
14. 90th percentile WT for CCAC services – Q3 2011/12

North West LHIN Operational Performance

The total number of staff at the North West LHIN as of March 31, 2011 was 36 full time equivalents. The North West LHIN operational budget was $5,031,192, which is less than 1% of the total LHIN-funded health care budget for Northwestern Ontario.

Table 2

Performance Indicator	LHIN 10/11 Starting Point	LHIN 11/12 Target	Most Recent Quarter 11/12	Annual Results	LHIN Met Target Yes/No
1. 90th Percentile Wait Times for Cancer Surgery	39 days	45 days	38 days	37 days	Yes
2. 90th Percentile Wait Times for Cataract Surgery	103 days	112 days	78 days	103 days	Yes
3. 90th Percentile Wait Times for Hip Replacement	176 days	176 days	266 days	194 days	No
4. 90th Percentile Wait Times for Knee Replacement	187 days	182 days	218 days	216 days	No
5. 90th Percentile Wait Times for Diagnostic MRI Scan	66 days	59 days	86 days	78 days	No
6. 90th Percentile Wait Times for Diagnostic CT scan	25 days	28 days	50 days	40 days	No
7. Percentage of Alternate Level of Care Days - by LHIN of Institution	21.76%	15.40%	18.78%	18.59%	No
8. 90th Percentile ER Length of Stay for Admitted Patients	28.83 hours	25.00 hours	29.80 hours	29.13 hours	No
9.90th Percentile ER Length of Stay for Non-Admitted Complex Patients	6.62 hours	6.50 hours	6.67 hours	6.68 hours	No
10. 90th Percentile ER Length of Stay for Non-Admitted Minor Uncomplicated Patients	4.12 hours	4.00 hours	3.83 hours	3.98 hours	Yes
11. Repeat Unplanned Emergency Visits Within 30 Days for Mental Health Conditions	19.30%	17.40%	15.78%	18.20%	Yes
12.Repeat Unplanned Emergency Visits Within 30 Days for Substance Abuse Conditions	32.30%	29.10%	26.58%	28.42%	Yes
13.Readmission Within 30 Days for Select CMG's	17.58%	16.00%	17.06%	16.86%	No
14. 90th Percentile Wait Times for CCAC In-Home Services – Application from Community Setting to Service Initiation	37.00 days	35.20 days	35.00 days	32.00 days	Yes

Financial statements of

North West Local Health Integration Network

March 31, 2012

North West Local Health Integration Network

March 31, 2012

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Independent Auditor's Report

To the Members of the Board of Directors of the
North West Local Health Integration Network

We have audited the accompanying financial statements of North West Local Health Integration Network, which comprise the statement of financial position as at March 31, 2012, and the statement of financial activities, changes in net debt and cash flows for the year then ended, and a summary of significant accounting policies and other explanatory information.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with Canadian public sector accounting standards, and for such internal control as management determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we comply with ethical requirements and plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained in our audit is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements present fairly, in all material respects, the financial position of North West Local Health Integration network as at March 31, 2012 and the results of its financial activities, changes in its net debt and its cash flows for the years then ended in accordance with Canadian public sector accounting standards.

Deloitte & Touche LLP

Chartered Accountants
Licensed Public Accountants
May 29, 2012

North West Local Health Integration Network

Statement of financial position
as at March 31, 2012

	2012	2011
	$	$
Financial assets		
Cash	**770,616**	668,646
Due from Ministry of Health and Long Term Care ("MOHLTC") Health Service Provider ("HSP") transfer payments (Note 9)	**993,674**	5,149,305
Accounts receivable	**103,835**	102,093
	1,868,125	5,920,044
Liabilities		
Accounts payable and accrued liabilities	**517,592**	571,855
Due to HSPs (Note 9)	**993,674**	5,149,305
Due to MOHLTC and eHealth Ontario (Note 3)	**340,467**	203,112
Due to the LHIN Shared Services Office (Note 4)	**16,392**	1,784
Deferred capital contributions (Note 5)	**301,096**	389,100
	2,169,221	6,315,156
Commitments (Note 6)		
Net debt	**(301,096)**	(395,112)
Non-financial assets		
Capital assets (Note 7)	**301,096**	389,100
Prepaid expenses	**-**	6,012
Accumulated surplus	**-**	-

Approved by the Board

Director

Director

North West Local Health Integration Network

Statement of financial activities
year ended March 31, 2012

	Budget (Unaudited) (Note 8)	2012 Actual	2011 Actual
	$	$	$
Revenue			
MOHLTC funding			
HSPs transfer payments (Note 9)	**566,779,083**	**606,341,278**	587,667,411
Operations of LHIN	**5,031,192**	**5,011,567**	4,806,240
Aboriginal Community Engagement (Note 11)	**160,000**	**160,000**	160,000
Emergency Department ("ED") LHIN Lead (Note 13)	-	**75,000**	75,000
Critical Care ("CC") LHIN Lead (Note 16)	-	**75,000**	75,000
Emergency Room/Alternative Level of Care ("ER/ALC") Performance Lead (Note 14)	-	**100,000**	100,000
Primary Care ("PC") LHIN Lead (Note 17)	-	**43,750**	-
French Language Health Services (Note 15)	**106,000**	**106,000**	74,670
Bahavioural Supports Initiative ("BSO") (Note 18)	-	**72,000**	-
E-Health (Note 12)	-	**600,000**	760,000
Amortization of deferred capital contributions (Note 5)	-	**107,629**	110,465
	572,076,275	**612,692,224**	593,828,786
Funding repayable to the MOHLTC (Note 3)	-	**(297,252)**	(203,112)
Funding repayable to eHealth Ontario (Note 3)	-	**(43,215)**	-
In year surplus recovered by MOHLTC (Note 3)	-	**(110,000)**	(78,000)
	572,076,275	**612,241,757**	593,547,674
Expenses			
Transfer payments to HSPs (Note 9)	**566,779,083**	**606,341,278**	587,667,411
General and administrative (Note 10)	**5,031,192**	**4,874,919**	4,733,985
Aboriginal Community Engagement (Note 11)	**160,000**	**131,173**	150,374
E-Health (Note 12)	-	**556,785**	760,000
ED LHIN Lead (Note 13)	-	**75,000**	75,000
CC LHIN Lead (Note 16)	-	**74,528**	75,000
Emergency Room/Alternative Level of Care ("ER/ALC") Performance Lead (Note 14)	-	**8,827**	22,000
Primary Care ("PC") LHIN Lead (Note 17)	-	**13,337**	-
French Language Health Services (Note 15)	**106,000**	**102,938**	63,904
BSO (Note 18)	-	**62,972**	-
	572,076,275	**612,241,757**	593,547,674
Annual surplus and closing accumulated surplus	-	-	-

North West Local Health Integration Network

Statement of changes in net debt
year ended March 31, 2012

	2012	2011
	$	$
Annual surplus	-	-
Decrease in prepaid expenses	**6,012**	591
Acquisition of capital assets	**(19,625)**	(399,953)
Amortization of capital assets	**107,629**	110,465
Decrease (increase) in net debt	**94,016**	(288,897)
Opening net debt	**(395,112)**	(106,215)
Closing net debt	**(301,096)**	(395,112)

North West Local Health Integration Network

Statement of cash flows
year ended March 31, 2012

	2012	2011
	$	$
Operating transactions		
Annual surplus	-	-
Less items not affecting cash		
Amortization of capital assets	**107,629**	110,465
Amortization of deferred capital contributions (Note 5)	**(107,629)**	(110,465)
Changes in non-cash operating items		
Decrease (increase) in due from MOHLTC - HSPs transfer payments	**4,155,631**	(4,593,949)
Decrease in due from MOHLTC - Internal LHIN Project Funding	-	90,000
Decrease in due from HNHB LHIN	-	12,057
Increase in accounts receivable	**(1,742)**	(102,093)
Decrease in accounts payable and accrued liabilities	**(54,263)**	(492,715)
(Decrease) increase in due to HSPs	**(4,155,631)**	4,593,949
Increase (decrease) in due to MOHLTC and eHealth Ontario	**137,355**	(907,423)
Increase (decrease) in due to LHIN Shared Services Office	**14,608**	(187)
Decrease in prepaid expenses	**6,012**	591
	101,970	(1,399,770)
Capital transactions		
Acquisition of capital assets	**(19,625)**	(399,953)
Financing transactions		
Increase in deferred capital contributions (Note 5)	**19,625**	399,953
Net increase (decrease) in cash	**101,970**	(1,399,770)
Cash, beginning of year	**668,646**	2,068,416
Cash, end of year	**770,616**	668,646

North West Local Health Integration Network

Notes to the financial statements
March 31, 2012

1. Description of business

The North West Local Health Integration Network was incorporated by Letters Patent on June 16, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the North West Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Districts of Thunder Bay, Rainy River and most of Kenora. The LHIN enters into service accountability agreements with service providers.

The LHIN is funded by the Province of Ontario in accordance with Ministry-LHIN Performance Agreement ("MLPA"), which describes budget arrangements established by the Ministry of Health and Long-Term Care ("MOHLTC") and provides the framework for the LHIN accountabilities and activities. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account. Commencing April 1, 2007, all funding payments to LHIN managed Health Service Providers ("HSP") in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized HSPs are expensed in the LHIN's financial statements for the year ended March 31, 2012.

The LHIN statements do not include any MOHLTC managed programs.

The LHIN is also funded by eHealth Ontario in accordance with the eHealth Ontario – LHIN Transfer Payment Agreement ("TPA"), which describes budget arrangements established by eHealth Ontario. These financial statements reflect agreed funding arrangements approved by eHealth Ontario. The LHIN cannot authorize an amount in excess of the budget allocation set by eHealth Ontario.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Basis of accounting

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital assets and impairments in the value of assets.

2. Significant accounting policies (continued)

Government transfer payments

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Deferred capital contributions

Any amounts received that are used to fund expenditures that are recorded as capital assets, are recorded as deferred capital contributions and are recognized as revenue over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets

Capital assets are recorded at historic cost. Historic cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Office furniture and fixtures	5 years straight-line method
Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Web development	3 years straight-line method

For assets acquired or brought into use during the year, amortization is provided for a full year.

Segmented information

A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently disclose information for all appropriate segments and therefore no additional disclosure is required.

Use of estimates

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC and eHealth Ontario

In accordance with the MLPA, the LHIN is required to be in a balanced position at year-end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

In accordance with the TPA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to eHealth Ontario.

The amount repayable to the MOHLTC and eHealth Ontario related to the current year activities is made up of the following components:

	Revenue	Expenses	2012 Surplus	2011 Surplus
	$	$	$	$
Transfer payments to HSPs	**606,341,278**	**606,341,278**	**-**	-
LHIN operations	**5,119,117**	**4,874,840**	**244,277**	182,720
Aboriginal Community Engagement	**160,000**	**131,173**	**28,827**	9,626
E-Health	**600,000**	**556,785**	**43,215**	-
ED LHIN Lead	**75,000**	**75,000**	**-**	-
Critical Care ("CC") LHIN Lead	**75,000**	**74,528**	**472**	-
ER/ALC Performance Lead	**100,000**	**8,827**	**91,173**	78,000
PC LHIN Lead	**43,750**	**13,337**	**30,413**	-
French Language Health Services	**106,000**	**102,938**	**3,062**	10,766
BSO Strategy	**72,000**	**62,972**	**9,028**	-
	612,692,145	**612,241,678**	**450,467**	281,112

The amount due to the MOHLTC at March 31 is made up as follows:

	2012	2011
	$	$
Due to MOHLTC, beginning of year	**203,113**	1,110,536
Funding repaid to MOHLTC	**(203,113)**	(1,110,536)
Funding repayable to the MOHLTC related to current year activities	**407,252**	281,112
In year surplus recovered by MOHLTC	**(110,000)**	(78,000)
Due to MOHLTC, end of year	**297,252**	203,112

The amount due to eHealth Ontario at March 31 is made up as follows:

	2012
	$
Due to eHealth Ontario beginning of year	-
Funding repaid to eHealth Ontario	-
Funding repayable to eHealth Ontario related to current year activities	**43,215**
In year surplus recovered by eHealth Ontario	-
Due to eHealth Ontario end of year	**43,215**

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") and the Local Health Integration Network Collaborative (the "LHINC") are divisions of the Toronto Central LHIN and are subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO and LHINC, on behalf of the LHINs are responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs. Any portion of the LSSO operating costs overpaid (or not paid) by the LHIN at year end is recorded as a receivable (payable) from (to) the LSSO. This is all done pursuant to the shared service agreement the LSSO has with all LHINs.

5. Deferred capital contributions

	2012	2011
	$	$
Balance, beginning of year	**389,100**	99,613
Capital contributions received during the year	**19,625**	399,952
Amortization for the year	**(107,629)**	(110,465)
Balance, end of year	**301,096**	389,100

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment extending to 2016. Lease renewals are likely. Minimum lease payments due in each of the next five years are as follows:

	$
2013	308,287
2014	253,855
2015	251,716
2016	80,154
2017	9,752
	903,764

The LHIN also has funding commitments to HSPs associated with accountability agreements. Minimum commitments to HSPs related to the next year, based on the current accountability agreements, are as follows:

	$
2013	285,146,970

The actual amounts which will ultimately be paid are contingent upon actual LHIN funding received from the MOHLTC.

7. Capital assets

	Cost	Accumulated amortization	2012 Net book value	2011 Net book value
	$	$	$	$
Office furniture and fixtures	316,711	265,478	51,233	47,377
Computer equipment	108,174	95,436	12,738	25,477
Leasehold improvements	684,628	447,503	237,125	316,246
Web development	7,250	7,250	-	-
	1,116,763	815,667	301,096	389,100

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported in the Statement of financial activities reflect the initial budget. The figures have been reported for the purposes of these statements to comply with PSAB reporting principles. During the year the government approved budget adjustments. The following reflects the adjustments for the LHIN during the year:

The final HSP funding budget of $606,341,278 is derived as follows:

	$
Initial HSP funding budget	566,779,083
Adjustment due to announcements made during the year	39,562,195
Final HSP funding budget	606,341,278

The final LHIN budget, excluding the HSP funding, of $6,243,317 is derived as follows:

	$
Initial budget	5,297,192
Additional funding received during the year	
E-Health	600,000
ED LHIN Lead	75,000
Critical Care Lead	75,000
ER/ALC Performance Lead	100,000
Primary Care Lead	43,750
Behavioural Support Initiative (BSO)	72,000
Amount treated as capital contributions made during the year	(19,625)
Final budget	6,243,317

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $606,341,278 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors as follows:

	2012	2011
	$	$
Operation of hospitals	**420,030,397**	408,839,069
Health Infrastructure Renewal Fund	**-**	3,600,688
Grants to compensate for municipal taxation - public hospitals	**105,375**	104,250
Long term care homes	**68,511,429**	63,272,414
Community care access centres	**42,902,747**	39,768,960
Community support services	**14,070,995**	12,860,141
Acquired brain injury	**1,817,347**	1,790,490
Assisted living services in supportive housing	**7,290,866**	6,495,038
Community health centres	**8,269,886**	8,078,314
Community mental health program	**30,733,101**	30,639,650
Addictions program	**12,609,135**	12,218,397
	606,341,278	587,667,411

The LHIN receives funding from the MOHLTC and in turn allocates it to the HSPs. As at March 31, 2012, an amount of $993,674 (2011 - $5,149,305) was receivable from the MOHLTC, and $993,674 (2011 - $5,149,305) was payable to the HSPs. These amounts have been reflected as revenue and expenses in the Statement of financial activities and are included in the table above.

10. General and administrative expenses

The Statement of financial activities presents expenses by function. The following classifies general and administrative expenses by object:

	2012	2011
	$	$
Salaries and benefits	**3,001,129**	2,761,176
Occupancy	**237,024**	217,535
Amortization	**107,629**	110,465
Equipment and maintenance	**45,325**	64,571
Shared services	**475,025**	359,497
Public relations and community forums	**10,526**	11,680
Professional fees	**14,500**	21,520
Travel	**150,039**	131,757
Staff development and recruitment	**122,724**	142,565
Consulting services	**381,910**	461,446
LHIN collaborative	**26,971**	50,000
Supplies, printing and office	**82,018**	92,712
Other board member per diems	**58,400**	74,265
Board chair per diems	**23,945**	39,725
Other governance and travel costs	**68,002**	126,520
Mail, courier and telecommunications	**69,752**	68,551
	4,874,919	4,733,985

11. Aboriginal Community Engagement

The Ministry of Health and Long-Term Care provided $160,000 (2011 - $160,000) in additional base operational funding which was annualized for the purposes of engaging the Aboriginal population and organizations in the North West LHIN. During 2012, $131,173 (2011 - $150,374) of expenses were incurred.

12. eHealth Ontario

eHealth Ontario provided $600,000 (2011 - $760,000) to the LHIN. The funds were used to cover the operational and project costs associated with the LHIN Project Management Office infrastructure and eHealth Ontario activities. During the year, $556,785 (2011 - $760,000) of expenses were incurred.

13. Emergency Department LHIN Lead

The Ministry of Health and Long-Term Care provided $75,000 (2011 - $75,000) in one-time funding to support the compensation of the North West LHIN Emergency Department (ED) LHIN Lead. During the year, $75,000 of expenses were incurred (2011 - $75,000).

14. ER/ALC Performance Lead

The Ministry of Health and Long-Term Care provided one-time funding in the amount of $100,000 (2011 - $100,000) to support the compensation of the LHIN ER/ALC Performance Lead in 2011/12. During the year, $8,827 (2011 - $22,000) of expenses were incurred.

15. French Language Health Services

The Ministry of Health and Long-Term Care approved one-time funding of $106,000 (2011 - $74,670) to support the LHIN in its French Language Services activities. During the year, $102,938 (2011 - $63,904) of expenses were incurred.

16. Critical Care Lead

The Ministry of Health and Long-Term Care provided one-time funding in the amount of $75,000 (2011 - $75,000) to support the compensation of the LHIN Critical Care Lead in 2011/12. During the year, $74,528 (2011 - $75,000) of expenses were incurred.

17. Primary Care Lead

The Ministry of Health and Long-Term Care provided one-time funding in the amount of $43,750 (2011 - $Nil) to support the compensation of the LHIN Primary Care Lead in 2011/12. During the year, $13,337 (2011 - $Nil) of expenses were incurred.

18. Behavioural Supports Initiative (BSO)

The Ministry of Health and Long-Term Care provided one-time funding in the amount of $72,000 (2011 - $Nil) to support the compensation of the LHIN BSO Initiative in 2011/12. During the year, $62,972 (2011 - $Nil) of expenses were incurred

19. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of approximately 32 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2012 was $286,504 (2011 - $204,724) for current service costs and is included as an expense in the Statement of Financial Activities. The last actuarial valuation was completed for the plan in December 31, 2011. At that time, the plan was fully funded.

20. Guarantees

The LHIN is subject to the provisions of the *Financial Administration Act*. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the *Financial Administration Act* and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s. 28 of the *Financial Administration Act*.

21. Comparative figures

Certain comparative figures have been reclassified to conform to the current year presentation.

North West Local Health Integration Network

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